SSI FACILITY INFORMATION AND DETERMINATION FORM

Determination Effective Date: _____

Do not use this precedent for case actions occurring more than 3 years after above date.

Date of Anticipated Change (Specify): _____

SECTION A - FIELD OFFICE IDENTIFICATION

1. Name of FO: 2. FO Address: 3. FO Code: 4. Phone #:

5. Area Designation Code:

SECTION B - FACILITY IDENTIFICATION

1. Facility Name: 2. Telephone No. (area code):

3. Street Address: 4. City, Borough, etc.:

5. State: 6. Zip code: 7. State/County Code:

8. Mailing Address if Different from Above: 9. Employer Identification No. (EIN)

10. Parent Office Name and Address (If none, enter "None" or "N/A") Servicing FO Name and Code:

11. List of Principal Facility Contacts: Attachments Yes ___ No___

Name: Title: Phone #: For (e.g., admissions, etc.)

SECTION C - DETERMINATION OF INSTITUTIONAL STATUS

1. The facility makes available some treatment or services in addition to food and shelter to four or more residents who are not related to the proprietor. (If "NO," the facility is not an institution-skip to Section F. Signature Sections)

INSTITUTION? YES ☐ NO ☐

2. Determination of public/private status:
   A. Name of private individual or entity or governmental unit having administrative control of the facility: _____
   B. Name of private individual or entity or governmental unit having fiscal control of the facility: _____

C. The facility is a public institution (If "NO," skip to block C.3.D.-Medicaid).
D. The facility is a penal institution (If "YES," there is no SSI eligibility for any resident unless block C.3.A is checked "YES.")

PUBLIC? YES ☐ NO ☐ PENAL? YES ☐ NO ☐

3. Provisions which allow eligibility/payment:
   A. The facility is a public emergency shelter for the homeless (PESH).

PESH? YES ☐ NO ☐

B. The facility is a publicly operated community residence (POCR). (Check "YES" only if the answer to all questions below is "YES.")
   1. The facility is designed to serve and actually serves no more than 16. ___ Yes ___ No
   2. The facility is physically removed from any large institution. ___ Yes ___ No
   3. The facility is community based. ___ Yes ___ No

POCR? YES ☐ NO ☐

C. The institution is public and offers a program of educational/vocational (ED/VOC) training designed to prepare the resident(s) for gainful employment.

ED/VOC? YES ☐ NO ☐

D. The facility (public or private) receives Medicaid payments. Note: Except as noted in 4., $30 Federal payment limit applies if Medicaid pays more than 50% of individual's cost of care-applicable to both public and private.

1. ☐ Medicaid Certified
2. ☐ Medicaid Certification Pending
3. ☐ NoMedicaid Certified
4. ☐ Title XIX Home and Community Based Waiver services (if checked, $30 payment limit does not apply)

MEDICAID? YES ☐ NO ☐

4. The facility offers the following type(s) of medical services.

☐ A. General Hospital
☐ B. Special Hospital-Specify _____
☐ C. Skilled Nursing
☐ D. Intermediate Care
☐ E. Intermediate Care for the Mentally Retarded
☐ F. Other

MEDICAL SERVICES?
YES ☐ NO ☒

5. The facility is a private nonprofit facility. (Check "YES" if either A. or B. are checked.)

A. ☐ IRS granted exemption under Sec. 501(a)_____ of IRC
B. ☐ Applied to IRS for exemption under Sec. 501(a)_____of IRC
C. ☐ Has not applied for exemption
D. ☐ IRS denied tax exemption

PRIVATE NONPROFIT?
YES ☐ NO ☐

6. A. Does the facility have charges and bill any resident (directly or through some other individual, organization, program, etc.)? If "YES" answer only B, C and E below.
B. Are there charges for all residents?
Yes ____ No ____
C. Same rate for same accommodations?
Yes ____ No ____
D. If "no" to B or C, note the conditions a resident must meet to qualify for no charges or to be charged at a lower rate for the same accomodations. If the facility is nongovernmental and nonprofit, note whether the exclusion of support and maintenance applies because of an express obligation to all residents. If the facility is publicly controlled by a State or political subdivision, explain whether the exclusion of assistance based on need applies to the food and shelter the facility provides all residents.
E. For residents who are not in a medical confinement or receiving excluded assistance based on need in the form of food and shelter (covered by an exclusion of income):
(1) What are the total charges per month (if a range, enter lower and upper amounts)? $ _____ $ _____
(2) What is the current market value of food and shelter? $_____ per month or _____ % of charges.

CHARGES?
YES ☐ NO ☐

SECTION D - PRERELEASE

1. The facility has been contacted regarding a prerelease agreement (if "NO," document below this statement or on RC why it is not appropriate and skip to Section E).

FACILITY CONTACTED?
YES ☐ NO ☐

2. If a prerelease agreement exists with the facility check "A" or "B" below.

☐ A. Formal Agreement
☐ B. Informal Agreement

AGREEMENT EXISTS?
YES ☐ NO ☐

SECTION E - SPECIAL PROVISION FOR 1619 ELIGIBLES

1. The facility (parent corp., etc.) has agreed to allow all appropriate individuals to retain continued SSI benefits under 1611 (e) (1) (E).
(If "NO," complete block E.2.)

BLANKET AGREEMENT FOR NON-MEDICAID RECIPIENT TO KEEP BENEFITS?
YES ☐ NO ☐ N/A ☐

2. The facility will consider agreements on an individual case basis.

INDIVIDUAL AGREEMENTS?
YES ☐ NO ☐

SECTION F - SIGNATURES

Prepared by: _____
Name Title Date
Reviewed by: _____
Name Title Date

SECTION G - INDIVIDUAL CASE DETERMINATION (OPTIONAL)

(Complete the following only on copies for individual case documentation.)
Case Name: _____
SSN: _____
Determination of Living Arrangements: _____
Determination of ISM: _____
Comments: